It Takes a Village: Collaborative Mental Health for the 21st Century Clinician

Collaborative Practice

Siloed Practice

Collaborative Care Model

Collaborative Care Conversations

From a Psychiatry Perspective

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Eduardo

- 82-year-old married Hispanic male living at home with his wife and adult daughter
- 1-year history of progressive cognitive and functional decline with insomnia and episodes of irritability and agitation
- Reports poor appetite and recent weight 10 lb loss; no acute medical problems noted
- He told his wife that some of the small neighbor kids were running in and out of the house
- His wife has obsessive-compulsive personality disorder

Multiple Clinicians Stirring the Pot

**PCP**
- Work-up Negative
- Insomnia → alprazolam
- Wt loss → cyproheptadine

**PSYCHIATRIST**
- Dx Depression → fluoxetine
- Insomnia → trazodone

**NEUROLOGIST**
- Dx Alzheimers → donepezil
- Agitation → quetiapine

**GERIATRIC PSYCH**
- Dx Lewy body dementia → noted symptoms of delirium and psychosis

Conflicts and Crisis

- Fluoxetine + cyproheptadine = Loss of SSRI effect + antihistaminic and anticholinergic effects
- Quetiapine + Lewy body dementia = Delirium
- Alprazolam + trazodone + quetiapine = Falls and excess sedation
- Alprazolam + cyproheptadine = Paradoxical agitation

**THE RESULT?**
A downward spiral into delirium and failure to thrive

A Collaborative Care Solution? PACE

- Program for All-Inclusive Care for the Elderly (PACE)
- Medicare and Medicaid funded demonstration project
- A capitated program run by a non-profit that provides comprehensive care for 55+ individuals living in the community at risk for nursing home placement
  - Single PCP to coordinate all care
  - Medical and mental health care
  - Daycare
  - Home health and social services

The POWER of PACE

There are 116 PACE programs in 32 states with 35,000 enrollees

The central goal is to reduce long-term care placement by optimizing medical and mental health care

Studies have shown significant:
- Decreases in rates of hospitalization, ED visits, and nursing home placement
- Increases in utilization of outpatient services
- Improvement in health status, quality of life, and functional status

Key Take-Aways

- Too many older patients have multiple clinicians operating independently and not always aware of or appreciative of age-associated medical issues and relevant medication risks
- Disjointed, uncoordinated care can have serious health consequences
- Transitions in care increase the risk of discontinuities in care (ie, the "telephone effect")
- PACE offers an ideal and growing model of collaborative care for the elderly patient

From a **Primary Care Physician Perspective**

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**Sabrina**

- 60-year-old with schizophrenia; on clozapine
- High-level coordination (via text) with psychiatrist
- Back pain radiating to left leg; sub-acute
- Radiograph (LS spine) mild OA
- MRI (LS spine) with undefined lesion in pelvis
- Admitted via ED (outlying hospital system) for pain control
- Neurologist started pregabalin; hospitalist stopped clozapine
  - Decreased mental status; increased hallucinations, paranoia
  - Family member felt due to Rx changes; med team said not so
- Obtained pelvic MRI; numerous lesions
- Communicated with oncologist; biopsy proved undiff CA
- Admitted to hospice

**Challenging the Traditional Model**

- A plurality of trials have evaluated collaborative care models for major depressive disorder
- Two 2012 systematic reviews evaluated a total of 69 randomized trials of collaborative care
  - Consistently more effective than traditional model
    - Higher response to treatment
    - Higher remission rates
    - Improved treatment adherence
    - Improved quality of life and functional status

**Key Take-Aways**

- Engage active family members, caregivers
- Get your notes to other team members... and demand the same
- Texting, e-mailing have a role to play
  - Connecting with patients
  - Connecting with caregivers
  - Connecting with care team members
- Choose consultants on ability... and availability
- Integrated health systems > non-integrated health systems

**From a Psychotherapy Perspective**

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**Melissa: “My Broken Heart”**

- 62-year-old female longstanding Hx of major depression and anxiety
- Taking an SSRI for 10 years prescribed by PCP
- No history of suicidal ideation or substance abuse issues reported
- Recent divorce – 20-year marriage. Current PHQ-9: 18 (moderately severe); GAD-7: 5 (mild anxiety)
- Depressive symptoms worsened during separation, divorce, and aftermath. Assessment for Panic Disorder negative
- PT reports seeing PCP = recent chest pains and dizziness. PCP felt complaints were attributable to anxiety
- Phone contact w/ PCP regarding current depression/anxiety + concerns related to chest pains and dizziness. Shared with PCP symptom presentation not adequately explained by anxiety. No evidence of Panic Disorder
- Requested referral to cardiologist for full evaluation. PCP agreed and cardiologist Dx unstable angina
Few Providers, BUT Multiple Roadblocks to Effectively Practicing Collaborative Care

- Solo private practices
- Practice in similar collaborative care models – A combination of Minimal and Basic at a Distance
- Separate facilities/systems
- Communication ranges from sporadic to increased communication via phone and/or letter
- Limited support staff to assist with communication efforts
- Busy schedules
- Playing phone tag
- Worries about HIPPA violations regarding e-mail and text messaging
- Lack of integrated EMR
- Lack of practice in effectively communicating concerns between specialties

Why is collaborative care so important?

An Example of Why Collaborative Care Matters

Data from the IMPACT (Improving Mood-Promoting Access to Collaborative Treatment) Randomized Controlled Trial Effect of Collaborative Care for Depression on Risk of Cardiovascular Events

235 primary care patients aged ≥ 60 years with major depression or dysthymia randomized to a 12-month collaborative care program involving antidepressants and psychotherapy or usual care

IMPACT patients (Collaborative Care) without baseline CVD had a 48% lower risk of an event than Usual Care patients

Why is collaborative care so important?

Collaborative Care and Depression: Relationships Matter!

Meta-analyses exploring the effectiveness of collaborative care in improving depression symptoms

PCP = primary care provider; CM = case managers; MHS = mental health specialists.

Improvements in Depression Symptoms

Meta-analyses suggests robust evidence of effectiveness of collaborative care in improving depression symptoms

BDI = Beck Depression Inventory; CES-D = Center for Epidemiologic Studies Depression Scale; GDS = Geriatric Depression Scale; HAM-D = Hamilton Rating Scale for Depression; HSCL = The Hopkins Symptom Checklist; MHI-D = Medical and Health Information Directory; PHQ = Patient Health Questionnaire; QIDS-SR = Quick Inventory of Depressive Symptomatology (self-report); SCID = Structured Clinical Interview; SCL = Symptom Checklist.

Key Take-Aways

- Prefer phone calls with HCPs when possible. Texts/e-mails (encrypted) viable option. Potentially problematic (HIPPA), but huge payoff – everyone involved wins
- Keep it brief and to the point! Time is of the essence. Find out their preferred form of communication
- Hierarchy of professionals – worry about “stepping on toes” when asking about referral to a cardiologist
- Develop a network of providers that are easy to work with and invite collaborative care
- Patients need an advocate, someone to set the game plan – next steps. If family member is available, consultation is required to confirm the plan

From a Physician Assistant Perspective

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Collaboration Behind Bars?

Jails and Prisons:
If they are the new “asylums”…?

De facto Mental Health Treatment

Bars to Collaborative Care

• 19-year-old white female, daughter of local physician, Mom an LPC, no previous psychiatric history, “dabbled” in cannabis, graduated w/ honors prestigious private girl’s school, completed freshman year at USC
• History obtained from mother: Pt returned home at end of year; isolative, secretive, irritable, parents suspected substance use. Admitted to local private psychiatric hospital; diagnosed Bipolar I; Lurasidone 20 mg, nonadherent; discharged home after 3 days
• Next day altercation w/ mother over cell phone; police called, arrested/charged w/ “interfering with 911 call”. Mother filed restraining order, feared for her life, would not allow patient to “ever” return home

Putting Pieces Together

• Acutely psychotic, AHs, delusional, ideas of reference; refusing medication, no hospital records available
• Family Hx: Maternal grandfather hospitalized; mother depression; mother’s nephew schizophrenia
• More Pt history – polysubstance use at USC; alcohol, cannabis, cocaine, hallucinogens; 5-day binge on K-2
• Recommended no bail. Patient found incompetent for trial; 120-day commitment recommended
• Negotiated Outpatient Competency Restoration; F/U CMHC and Probation Department
• Care transferred to private provider; attend AA
• 6 months later: enrolled as commuter student at local university; 6 semester hours, living with parents

Transinstitutionalization

How Do We Navigate between Systems?

• Legal charges and prosecution by State; patient’s defense by Public Defender
• Confounding treatment with “punishment”
• Providing treatment that will potentially optimize any possibility of restoration of functioning
• Support family, provide family education, assure mother of safety and a “net”
• Communication outside of the medical community and interface with legal system and Court, case management

Percentage of Jail and Prison Inmates
With Serious Mental Illness


Transinstitutionalization in the United States (per 100,000 adults)

Breaking Down Barriers

- Communication: key to unlocking bars/barriers
  - Family history
  - Records from private hospital
  - Communication and advocacy prosecutor and Court
  - Advocacy for least restrictive level of care
  - Maintaining sobriety – AA
  - Outpatient community MH Clinic
  - Transfer of care to private practice provider

- Conclusion: Incarceration provided the optimal “long-term care” with disposition and treatment goals, and outcomes negotiated between multiple systems

From a Nurse Practitioner Perspective

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Key Take-Aways

- Patient is at center of patient-centered care
- Communication, networking, education, and cooperation are the ingredients for collaborative care
- Collaboration can transcend multiple disciplines and multiple systems

Andrew’s Case: East Bay Ray

- 60-year-old married man, treated for several years for dysthymia/MDD
- Longstanding familial cardiomyopathy, now worsening, facing risky surgery to manage
- Diagnosed with Lewy Body Disease, largely asymptomatic with cholinesterase inhibitors
- Followed (actively) by Kaiser PCP, Myself, Cardiologist, Neurologist, Private Neurologist, two 2nd opinion cardiac surgeons (one Kaiser, one outside Kaiser), in the time I have seen him, he has also seen 2 different private practice psychotherapists
- Kaiser has robust EMR capacity. It does not interface well outside of Kaiser

Too Many Cooks in the Kitchen?

- Cardiologist is concerned about hypertensive risks of additional medication doses (of bupropion and modafinil)
- Neurologist is concerned that he is still depressed despite treatment, sends me a somewhat insulting e-mail offering to set him up with a psychiatrist in the community (Pt is copied on this message to me)
- Cardiac surgeon hadn’t given much thought to the risks of general anesthesia and bypass machine on Lewy Body Disease
- Psychologically, Pt is struggling with potential end-of-life or long period of dependency and disability

How Do We Communicate When There are So Many Providers Involved?

- Should the PCP be the “captain of the ship?”
  - Will specialists cede control to a PCP?
  - Do PCPs have the time to manage so many aspects of care? The knowledge?
- How do we remain “specialty focused” without losing sight of “the big picture.” Can we as MH professionals serve as brokers/emissaries for the Pt?
- How do we approach our colleagues when we are not sure about the care they are providing?
- EMRs within a health care system can help facilitate care, but what about when the care is also provided outside the system?
Relationships Matter: There’s No Substitute for a Conversation

Types of hand-off media


Good Communication Should be the Norm, Not a Surprise

- Face-to-face is still best, but time consuming and difficult across systems
- Use EMRs to communicate to all members of the care team
- Use (encrypted) e-mail or voice messages to communicate to people outside the system
- Be thoughtful about copying Pts on collegial communications, especially if there is a disagreement involved – Pts need to feel confident before they enter care, any disagreements have been resolved – (they don’t need to see mom and dad fighting)


When We Talk, Let’s Assume We’re All Doing the Best Job We Can

- Physicians who use shaming tone in their communications are perceived as being less competent than their peers who utilize a more neutral (or even angry) tone
- Shaming can be done in large gestures or small microaggressions. Both are damaging
- Guilt (“I acted badly”): motivates change
- Shame (“I am bad. I am not good enough”): motivates hiding, lying, blame, and rage


In Conclusion

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Key Take-Aways

- Communication is easiest when providers are embedded within the same system. When providers are outside the system or EHR, there is more risk for miscommunication
- Taking the time to develop relationships with fellow providers, both within and outside your system of care will provide for better outcomes for our patients
- Start to notice the tone with which we address our colleagues. Avoid communication styles that are shaming


If What We Say Matters to Patients, Shouldn’t It Matter between Colleagues?
